SECTION 2

PODIATRIC SERVICES

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1 PODIATRIC SERVICES

The purpose of the podiatry program is to increase the functioning ability of the Medicaid recipient. Podiatric services include the examination, diagnosis and treatment of the human foot through medical, mechanical or surgical means. Services may be performed by a physician, osteopath, or podiatrist as specified by the respective professional license. Podiatric service may be provided to a Medicaid recipient who has a foot problem that causes:

1. difficulty walking or inability to walk;
2. painful or distressing impairment which limits independent function; or
3. crippling.

Services for Children and Pregnant Women

Medicaid covers all podiatric services described in Chapter 8, Reimbursement for Podiatry Services, for children from birth through age 20 and for pregnant women.

Restriction of Services for Non-pregnant Adults

For dates of service July 1, 2002, through September 30, 2002, Medicaid does NOT cover podiatric services to non-pregnant adults age 21 and older. For dates of service on or after October 1, 2002, Medicaid restored coverage of a limited number of podiatric services to non-pregnant adults age 21 and older. Refer to Chapter 8, Reimbursement for Podiatry Services.

1 - 1 Client Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO), must receive all health care services through that plan. Refer to SECTION 1, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1,Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Client NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Co-payment Requirement for Non-pregnant Adults

Many non-pregnant, adult Medicaid clients are required to make a $3.00 co-payment for office visits performed by a podiatrist, when the service is covered by Medicaid. Services include those performed in a Federally Qualified Health Center (FQHC). Both HMO and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. The amount of the client's co-payment will automatically be deducted from the claim reimbursement. Requirements specific to podiatric services are stated below.

For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, and an example of the co-payment message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

A. Clients Exempt from Co-payments

If there is not a co-payment message under a client's name, the client does not have a co-payment. Also, do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

B. Co-payment per Medical Visit

Except for exempt clients described in item A, Medicaid clients have a $3.00 co-payment for podiatric visits.

2 DEFINITIONS

The "practice of podiatry" means the examination, diagnosis, or treatment medically, mechanically or surgically of the ailments of the human foot. In accordance with Utah Code Annotated 58-5-1, the practice of podiatry is limited to the human foot.

A "prosthetic device" means a replacement, corrective or supportive device prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to:

A. artificially replace a missing portion of the body;
B. prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or
C. support a weak or deformed portion of the body.

3 COVERED SERVICES

Covered podiatric services are limited to examination, diagnosis, and treatment described in this chapter.

3 - 1 Podiatric Services

Podiatric services include the following:

- Foot incision
- Foot excision
- Repair, revision or reconstruction
- Nail treatment, subject to limitations described in Chapter 4, Limitations.
- Radiology
- Reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendinitis, and other related conditions that result from, or are associated with, partial displacement of foot structures.
- Surgical correction in the subluxated foot structure only when it is an integral part of the treatment of a foot injury.
- Surgical correction undertaken to improve the function of the foot or to alleviate an associated symptomatic condition is also a covered service.
- Medical supplies and materials used by the podiatrist over and above those usually included for the surgical procedure.

3 - 2 Shoes and Shoe Repair

A. Shoes are a Medicaid benefit only when:
   (1) attached to a brace or prosthesis; or
   (2) especially constructed to provide for a totally or partially missing foot. The previous amputation must be documented and diagnosis of diabetes with previous foot ulcerations.

B. Shoe repair is covered only when it relates to external modification of an existing shoe to meet a medical need, for example, leg length discrepancy requiring a shoe build up of one inch or more.

4 LIMITATIONS

Limitations which apply to services provided by a physician or osteopath also apply to services provided by a podiatrist.

1. Treatment of a fungal (mycotic) infection of the toenail is covered if there is documented clinical evidence of mycosis that causes limitation of ambulation or pain.

2. A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.

3. Palliative care must include the specific service and must be billed by the specific service and not by using an evaluation and management (office call) procedure code.

4. Podiatry services for recipients residing in long term care facilities have the following limitations:
   (a) Foot care performed by an employee of the facility is not covered.
   (b) Visits are limited to one visit every 60 days.
   (c) Debridement of mycotic toenails is limited to once every 60 days.
   (d) Trimming corns, warts, callouses or nails is limited to once every 60 days.
   (e) Podiatrist visits (evaluation and management) are not covered, only the actual services performed are covered.

5 NON-COVERED SERVICES

Any service not listed as covered is not a Medicaid benefit. The following services are not covered:

1. Preventive maintenance, routine foot care, ordinarily within the realm of self care or nursing home care considered to be routine is not a benefit. This includes:
   A. The removal of corns, warts or callouses unless a danger to the patient exists (for example: diabetes, arteriosclerosis or Buerger's disease).
   B. The trimming, cutting, clipping, or debriding of nails (including mycotic nails).
   C. Other hygienic and preventive maintenance care, such as cleaning and soaking of the feet, the use of massage or skin creams to maintain skin tone of either ambulatory of bedfast patients, and any other service performed in the absence of localized illness or injury.
   D. Any application of topical medication or any treatment of fungal (mycotic) infection of the toenail, except when there is limitation to ambulation or pain.

2. Supportive devices including arch supports, orthotics, or metatarsal head appliances are not a benefit.

3. Treatment and evaluations of subluxation or flat feet is not a benefit.
   A. The treatment, including evaluation, of subluxations of the feet. These are structural misalignments, or partial dislocation (other than fractures or complete dislocations) of the joints of the feet which require treatment only by nonsurgical methods regardless of underlying pathology.
   B. The treatment, including evaluations and the prescriptions of supporting devices, of the local condition of flattened arches regardless of the underlying pathology.

4. Shoe repair except as it relates to external modification of an existing shoe to meet a medical need, i.e., leg length discrepancy requiring a shoe build up of one inch or more.

5. Internal modification of a shoe is not a benefit.

6. Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.

7. Special shoes such as:
   A. mismatched shoes (unless attached to a brace);
   B. shoes to support an overweight individual;
   C. trade name or brand name shoes considered "orthopedic" or "corrective";
   D. "athletic" or "walking" shoes.

8. Arch supports, foot pads, metatarsal head appliances or foot supports.

9. Personal comfort items and services. Comfort items include, but are not limited to arch supports, foot pads, “cookies” or other accessories, shoes for comfort or athletic shoes.

10. The manufacture, dispensing, or services related to orthotics of the feet.

6 PODIATRIC SERVICES FOR RESIDENTS OF A LONG TERM CARE FACILITY

1. Medicaid recipients who reside in a nursing home or long term care facility may receive benefits from the podiatry program as indicated in covered services.

2. Limitation of Service for Residents of a Long Term Care Facility.
   A. Foot care which may be performed by an employee of the facility is not a Medicaid benefit.
   B. Foot care is limited to one visit every two months. Services in excess of this standard require prior authorization.
   C. The debridement of mycotic toenails is limited to once every 60 days. Services in excess of this standard require prior authorization. (See limitations in Chapter 4)
   D. Trimming corns, warts, callouses or nails is limited to once every 60 days for patients with diabetes, arteriosclerosis, or Buerger's Disease. Services in excess of this standard require prior authorization.
   E. Payment for nursing home visits (Evaluation and Management) is not a benefit. Only the services performed can be billed.

3. Surgical procedures on Medicaid recipients who reside in a nursing home are subject to post payment review. Recovery of payment will be made if the service was not appropriate.

7 PRIOR AUTHORIZATION

Some services, particularly surgical services, require the podiatrist to obtain prior authorization from Medicaid before service is provided. All requests for prior approval must be made before the surgery or service is performed, except for recipients made retroactively eligible for Medicaid.

The only exceptions to obtaining prior authorization before service is provided are in life threatening or justifiable emergency situations. Refer to SECTION 1, Chapter 9, Prior Authorization Process, for additional information.

7 - 1 Prior Authorization Requests

Prior authorization requests must include the following information:

A. the diagnosis and the severity of the condition;
B. the prognosis;
C. the expected independence of the recipient or benefit of the procedures;
D. the procedure code(s);
E. the patient x-rays (if applicable);
F. adequate clinical assessment of patient needs.

7 - 2 Services to Residents of a Long Term Care Facility Which Require Prior Authorization

A. **Prior authorization is required** for the debridement of mycotic toenails when required more frequently than once every 60 days.
B. **Prior authorization is required** if trimming corns, warts, callouses or nails is performed for any patient with diabetes, arteriosclerosis, or Buerger's Disease, when required more frequently than every 60 days.

8 REIMBURSEMENT FOR PODIATRY SERVICES

The procedure codes in the attached list are reimbursable by Medicaid to podiatrists. Procedure codes which may be billed are identified by CPT codes found in the Healthcare Common Procedure Coding System (HCPCS).

1. Evaluation and Management visits

   Evaluation and Management visits are not designated by the time involved but by the service provided. The CPT identifies the elements and services included in each level of office visit or home visit. All evaluation and management visits shall not be billed in addition to a service.

2. Palliative care must include the specific service and must be billed by the code for the specific service and not by a code for an office call.

3. Podiatry services require a $3 per visit copayment by recipients who are required to pay a copayment; see the Medicaid Eligibility Card for who is required to make a copayment. The copayment amount will be deducted from the reimbursement paid by Medicaid to the provider. See 1.3, Copayment requirements for non-pregnant adults above.

Podiatry Codes Covered by the Utah Medicaid Program

Injection Procedure Codes

	CPT Code	Descriptor	[1] Restriction of Services
	J0670	injection, mepivicaine	yes
	J0690	injection, cefazolin sodium, up to 500 mg	yes
*	J0696	injection, ceftrizxone Sodium, per 250mg	yes
	J1100	injection, dexamethasone, sodium phos	yes
	J2000	injection, lidocaine Hcl	yes
	J2175	injection, meperidine Hcl, Per 100 mg	yes
*	J2920	injection, methylprednisolone sodium	yes
	J3301	injection, triamicinolone acetonide	yes
	J3302	injection, triamicinolone diacetate	yes

[1] **Restriction of Services** means the service is covered only for pregnant women and clients age 20 and younger.
Codes in bold print are newly added to this list.

CPT Codes

CPT Code	Descriptor	[1] Restriction of Services
10060	incision and drainage of abscess, simple	
10061	incision and drainage of abscess, complex	yes
11000	debrd extnsv, exem/infct skin <10% bdy	
11040	debredment; skin, partial thickness	
11041	debredment; skin, full thickness	
11042	debredment; skin & subcutaneous tissue	
11043	debredment; skin, part.thick; subcut. tissue	
11044	Debridement, skin subcantous tiss, mus,bo	
11055	paring/cutting be. les. (corn or callous)	
11056	paring/cutting be. lesions	
11057	paring/cutting be. lesions	
11100	biopsy, skin, subcut tissue/mucous mem	yes
11420	exc ben les/ lgs, ft >0.5 cm	yes
11421	exc ben les/ lgs, ft .6-1cm	yes
11422	exc ben les/ lgs, ft 1.1-2cm	
11719	Trim nondystrophic nails, any number	
11720	debredment of nails, by any method; on	
11721	debredment of nails, by any method; si	
11730	avulsion nail plate, single	
11732	avulsion nail plate, each additional	

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CPT Code	Descriptor	[1] Restriction of Services
11740	evac of subungual hematoma (nail)	yes
11750	exc nail & matrix, partial or complete	
11752	exc nail, with amp of tuft distal phalanx	yes
11755	Biopsy of nail unit, any method	yes
11760	Repair of nail bed	yes
11762	Reconstruction of nail bed with graft	yes
11765	Wedge Exc nail fold, (ingrown nail)	yes
12001-12004	Simple Wound Repair	yes
17000	Destructions benign lesion any method	
17003	Dest benign 2nd to 14 lesions any method	yes
17004	Dest benign lesions 15 or more	yes
17110	destruct, any meth, warts mollus, milia,	yes
17111	. . . . . 15 more lesions	yes
17250	chemical cauterization of granulation tis	yes
20550	inject, tendon sheath, ligmt/trigger pt	
20600	arthocentesis, asp/inject, small joint	yes
20670	removal wire, pin screw superficial	yes
27630	exc. lesion tend, sheath or capsule ankle	yes
27647	Partial exc, bone talus or calaneus	yes
27695	repair, primary, disrupted lig. Anke; coll	yes
27696	prim suture both collateral ligament ank	yes
27698	repair, second distrupted lig, ankle, colla	yes

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CPT Code	Descriptor	[1] Restriction of Services
27760	closed trmt medial malleaolus fracture	yes
27762	close trmt medial malleaolus fx: manip	yes
27814	open trmt bimalleolar ankle fx, w w/o in/exter fixation	yes
28001	incision and drainage, bursa, foot	yes
28002	incision and drain, with or without tend sheath	
28003	multiple areas	yes
28005	incision bone cortex, foot	
28008	fasciotomy, foot and or toe	yes
28010	tenotomy, percutaneous, toe; single tend	yes
28011	tenotomy, percutaneous, toe; mulitple	yes
28020	arthrotomy explor, drain, remvl foreign	yes
28022	arthort w/explr. drain, metatarsophalang	yes
28024	arthrot w. epxlr, drain, interphalang toe	yes
28030	neurectomy, intrinsic musculature of foot	yes
28035	release, tarsal tunnel (post tibial nerve)	yes
28043	excision, tumor foot, subcutaneous tiss.	yes
28045	deep subfacial, intramuscular	yes
28050	arthotomy w. biopsy interater/ tarsosme	yes
28052	arthotomy for bio, metatarsophalangeal	yes
28054	arthotomy for bio, interphlangeal joint	yes
28060	fasciectomy, plantar fascia, partial	yes
28062	exc plant fascia part radical, indep prokl	yes

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CPT Code	Descriptor	[1] Restriction of Services
28070	synovectomy, intertarsal/tarsometatarsal	yes
28072	synovectomy metatarsophalgea	yes
28080	excision, interdigital (morton) neuroma,	
28086	synovectomy, meta tarsophalalngeal	yes
28088	extensor	yes
28090	excision lesion, tendon, tendon sheath	
28092	. . . toes	yes
28100	to exc/curt bn cyst ben tum, astracl	yes
28104	exc/curett bone cyst/tum, tarsal/metatars	yes
28108	exc/curett bone cyst/benign tum, phalang	yes
28110	part exc.5th metatarsal	
28111	ostectomoy, comp excision, 1st metatarsl	yes
28112	ostectomy, 2,3,4, metatarsal heads	yes
28113	ostectomy, 5th metatarsal head	yes
28114	ostectomy, complex; metatarsl head, excl	yes
28116	excision tarsal coalition	yes
28118	ostectomy, calcaneus	yes
28119	ostectomy, for spur	yes
28120	partial excision bone; talus or calcaneus	
28122	partial excision bone; tarsal or metatarsal	
28124	partial excision, bone; phalanx of toe	
28126	resection, part or comp, phalan base, toe	yes

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CPT Code	Descriptor	[1] Restriction of Services
28140	metatarsectomy	yes
28150	phalangectomy, toe, each toe	yes
28153	resection, condyles, distal end phalanx	yes
28160	hemiphalangectmy/interphalng joint exc,	yes
28171	radical resection tumor, bone; tarsal	yes
28173	radical resection of tumor, bn metatarsal	yes
28175	radical resection of tumor, bn phalanx toe	yes
28190	remove foreign body; subcutaneous	yes
28192	deep	
28193	complicated	yes
28200	repair, tendon, flex, foot, prim sec, w/o	yes
28220	tenolysis, flexor, foot; single tendon	yes
28222	tenolysis, flexor, foot; multiple tendons	yes
28225	tenolysis, extensor, foot; single tendon	yes
28226	tenolysis, extensor, foot; multiple tendon	yes
28230	tenotomy, open, tend flexor; ft, sg or mul	yes
28232	tenotomy, open tendon, flexor; toe, single	yes
28234	tenotomy, open, extensor, foot or toe, each	yes
28238	reconstruc, post tibilal tend with exc navicular bone	yes
28270	capsulotomy, metatarsphal joint, with or without ten	yes
28272	capsulotomy; interphalangeal joint, each joint	yes

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CPT Code	Descriptor	[1] Restriction of Services
28280	Syndactylization toes (kelikian proc)	yes
28285	correction, hammertoe	
28286	correction, cock-up fifth toe, with plastic sk	yes
28288	ostectomy, part, exostec/condylectomy	yes
28289	hallux rigidus corr, first metatarsal joint	yes
28290	corr, hallux valgus with or without sesamoidecto	yes
28292	ostectomy, keller, mcbride, mayo type	yes
28293	arthroplsty metatarsal w/resct/implnt j	yes
28296	arthoplasty metatarsal with osteotomy	
28298	bunion correction; by phalnx osteotomy	yes
28299	by other methods (eg. double osteotomy)	yes
28307	ostectomy, with or without lght, short, with graft	yes
28308	ostectomy, with or without lgth, short met; other	
28309	ostectomy, with or without lgth, short, multiple	yes
28310	ostectomy, shor, angul/rotat corr; 1st phal	yes
28312	ostectomy, os calcis, oth phalang, any toe	yes
28313	reconstructioin, angulr deformity toe, soft	yes
28315	sesmoidectomy, first toe (separate proc)	yes
28320	repair, nonunion or malunion; tarsal bone	yes
28322	repair, non/malunioin metatarl with or without graf	yes
28340	reconstruct toe macrdactyly; soft tiss	yes
28344	recontruct toes; polydactyly	yes
28345	recontruct, syndactyly, with or without graft	yes
28470	Closed trmnt metatarsal fracture; w./o manipulation, ea	
28505	Open treatment of fracture of great toe, phalanx, phalanges, with or without fixation	yes
28510	Closed treatment of fracture, phalanx or phalanges other than great toe, without manipulation	yes

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CPT Code	Descriptor	[1] Restriction of Services
28515	Closed treatment of fracture, phalanx or phalanges other than great toe, with manipulation	yes
28820	Amputation toe; metatarsophalangeal joint	
29405	application short leg cast (below knee-toes)	yes
29425	walking or ambulatory type cast	
29450	appl club foot cast/mldng/manip, lg/sh	yes
29550	strapping, toes	yes
29580	unna boot	
64450	nerve block oth peripherl nvrs or branch	yes
99070	supplies & materials over ususal off visit	yes
99202	office/outpat visit new	
99212	office/outpat visit established patient	
99242	office consultation new/establ patient	yes
99252	initial inpatient consultation	yes

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Codes in bold print are newly added to this list.

Radiologic Procedures

CPT Code	Descriptor	[1] Restriction of Services
73600	radiologic exam, ankle; ant/post/lat view	yes
73610	rad exam, ankle; complete, min 3 views	
73620	rad exam, foot; ant/post/lat view	
73630	rad exam, foot; complete, min 3 views	
73650	rad exam, calcaneous; min 2 views	yes
73660	rad exam, toe or toes, min 2 views	yes

Miscellaneous

CPT Code	Descriptor	[1] Restriction of Services
A4570	splint	yes
A4580	cast supplies	yes
A4590	special cast material (eg fiberglass)	yes

*

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